Pharmacist Brown-Bag Events

A “Brown Bag” medication review is a common practice that urges patients to bring all of their medications, including over-the-counter medications and herbal supplements, for a visit with their pharmacist or primary provider. Traditionally, patients bring their medications in a brown lunch bag to the encounter. The medication review identifies drug-drug interactions and/or drug-disease interactions. Patients discuss how they are taking the medications and any side effects they experience. In addition, the medication review informs the patient about the medications and the indications to clarify any confusion or misunderstandings. During the visit, the pharmacist or physician assesses if the patient is taking the correct dosage strength and frequency, and identifies if any medications are outdated or discontinued. Patients are encouraged to ask questions during the visit in order to clarify information regarding their medications or disease state.

Tranexamic Acid (Cyclokapron®)

Tranexamic acid, also referred to as TXA, has been on the formulary since 2013 to reduce bleeding and transfusion requirements in patients undergoing total hip or total knee arthroplasty. The previous restrictions for using this agent have been reduced. Current contraindications include: allergy to TXA; MI, CVA, DVT, or PE in the past 6 months; cardiac stent in the past year. Other considerations include: history of TIA, color blindness, hypercoagulability disorder, seizure disorder, or DIC; renal insufficiency; patients receiving prothrombin complex concentrate; SAH; and chronic anticoagulant use.

Clevidipine (Cleviprex®)

Clevidipine is an injectable emulsion for direct infusion indicated to reduce blood pressure when oral therapy is not considered appropriate or suitable. Clevidipine is a dihydropyridine calcium channel blocker that is administered via continuous infusion. Clevidipine is an alternative to nicardipine, which is also on our formulary. Clevidipine has a shorter half-life than nicardipine (15 minutes vs. 14 hours, respectively) and does not have CYP3A4, 2D6, 2C9, and 2C19 interactions that are associated with the use of nicardipine.

Suggamadex (Bridion®)

Suggamadex is indicated for short term use as a neuromuscular blockade reversal agent. It is administered intravenously as a single bolus injection over 10 seconds and follows weight based dosing. In clinical trials, suggamadex was found to have a rapid onset of 2-3 minutes. Additional neuromuscular blockade reversal agents on formulary at TVH include neostigmine and glycopyrrolate.

Correction from Spring 2016 issue: Lactated Ringers

The previous issue incorrectly described the composition of lactated ringers. Lactated ringers does not contain dextrose and has an osmolarity of 273 mOsm/L. Lactated ringers contains: sodium chloride, potassium chloride, sodium lactate, calcium chloride, and monobasic potassium phosphate.

We apologize for the error.

In this issue:

- Pharmacist “brown bag” - P. 1
- Sunscreen labels – P. 2
- Medical mission – P. 3
- Drug Info Corner: analgesics and breastfeeding - P. 5
- Formulary update - P. 6

Editors in Chief:
Maria Leibfried, PharmD
Carlo Lupano, RPh

Editorial Director:
Ron Krych, RPh

Editorial Advisor:
Tomas Hiciano, RPh

Editor:
Sapna Shah, PharmD

 Contributors:
Faiza Ahmad
Angela Miles
Parisa Karimi, PharmD
A. Sasha Libman, PharmD
David Montgomery, MD

www.valleyhealth.com/pharmacy
Interpreting the New Sunscreen Labels
Angela Miles and Faiza Ahmad, FDU PharmD Candidates 2016

Sun protection is vital as exposure to the sun can cause premature skin aging and increase the risk of skin cancer. There are many important preventative measures that should be followed for sun protection, one of which includes sunscreen. In 2012, US federal law mandated standardized labeling and language for sunscreen products in order to eliminate misleading claims, and to facilitate consumer label interpretation and product selection. The informative elements of the new sunscreen label include:

- **SPF** - (Sun Protection Factor) A number that rates effectiveness in blocking UV rays. The higher the SPF number, the higher the amount of sun protection. The FDA recommends using an SPF of 15 or higher when a person is exposed to the sun, even on cloudy or cool days. However, there is insufficient data to show that sunscreens with an SPF > 50 amounts to better sun protection.

- **Broad-spectrum** - There are two types of harmful ultraviolet (UV) rays from the sun: UVA and UVB. Both UV rays can cause skin cancer, sunburn, and premature skin aging. Therefore, it is important to use broad spectrum sunscreen as this protects against both UVA and UVB.

- **Water resistant** - According to FDA, manufacturers cannot label sunscreens as “waterproof” or “sweat proof” because these are false claims. Manufacturers can only label sunscreens as “water resistant for 40 minutes or 80 minutes when swimming or sweating.”

- **Drug Facts Label** - All sunscreen bottles must include the “Drug Facts Label” on the back of the bottle.

Regardless of the sunscreen product applied, it is important to **reapply sunscreen every 2 hours.** It is also important to check the expiration date of sunscreen. Sunscreen without an expiration date is good for 3 years or less depending on exposure to high temperatures.

For more information, visit [http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049090.htm](http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049090.htm)

References

Drug Info Corner
By: Alexandra “Sasha” Libman, PharmD, FDU Faculty

**Question:** What analgesics can be used in breastfeeding mothers?

**Answer:** Special consideration should be taken when women who are receiving opioid pain therapy are breastfeeding. Since women may use hydrocodone, oxycodone, methadone and other opioid analgesics while breastfeeding, infants should also be monitored for sedation and apnea. Opioid doses in breastfeeding mothers should be considered and potential risks versus benefits should be assessed. Rare reports of CNS depression and lethargy have been reported in nursing infants. Infants should be monitored for withdrawal symptoms when maternal administration of opioid analgesics is stopped or when the mother discontinues breastfeeding.

After C-section procedures, using NSAIDs alone or in combination with opioids can improve pain control by assisting with pain associated with uterine cramping. NSAIDs may also help minimize the total daily dose of opioids needed to control pain. In general, NSAIDs are safe to use in breastfeeding mothers.

Below, is a summary table of considerations for commonly used analgesics and NSAIDs in breastfeeding mothers.

<table>
<thead>
<tr>
<th><strong>ANALGESICS</strong></th>
<th><strong>Ideal analgesic for breastfeeding mothers due to:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphin</td>
<td>Limited transport to milk</td>
</tr>
<tr>
<td>Meperidinex/pethidinex (and metabolite: normeperidinex)</td>
<td>Frequently associated with dose-related neonatal sedation</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Has frequently been used in breastfeeding mothers</td>
</tr>
<tr>
<td>Codeine</td>
<td>Use with caution in breastfeeding mothers</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Levels in milk are known (average: ~58 µg/L, range 1.130 µg/L)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>NSAIDs</strong></th>
<th><strong>Ideal analgesic for breastfeeding mothers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen</td>
<td>Considered ideal, moderately effective analgesic</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>Potent analgesic, no sedative properties, transfer to milk is extremely low</td>
</tr>
<tr>
<td>Naproxen</td>
<td>GI disturbances reported in some infants following prolonged therapy</td>
</tr>
</tbody>
</table>

We are happy to publish an interview with Dr. David Montgomery of TVH, where he shares some of his experiences from a Medical Mission in Haiti.

Q: Please tell us about yourself and your role at The Valley Hospital.
Dr. M: My father was a missionary to Taiwan and I lived there until I was 10 years old. I went to Dartmouth for my undergraduate degree and Cornell Medical School then NY Hospital for my medical training. I did my Cardiology fellowship at Emory University in Atlanta. I joined William Lee, a cardiologist at Valley 21 years ago. I have been in private practice for 21 years with my office in Oakland. I am currently Director of the Division of Cardiology.

Q: What inspired you to start going on Medical Missions in Haiti?
Dr. M: Our Church, West Side Presbyterian Church in Ridgewood, has supported an orphanage in Haiti called Pwoje Espwa (Project Hope) since it was founded around 15 years ago with 8 boys. It now houses over 400 boys and 150 girls, runs a soup kitchen for the community, a school for all the kids and vocational training for when the kids grow out of the orphanage. There is a clinic on the grounds which serves the kids and the local community. The orphanage is in a fairly rural setting outside the city of Les Cayes on the southern coast of Haiti. We had supported it financially but never traveled there until 4 years ago. I have had the opportunity to go 3 times in the last 4 years. When we go, we bring a medical team of 2 or 3 doctors (usually a pediatrician), a dental team, and a construction team.

Q: Can you share with us the logistics of seeing patients during the mission?
Dr. M: We arrive on a Sunday evening. We wake at 6 am or so, breakfast at 7 and start working at the clinic at 8 am. Each of the physicians has a room and an interpreter. We start seeing patients and probably see between 30-40 per physician per day. Some days we take a half day and go to the public hospital in the city of Les Cayes to round with the doctors and usually give a talk to the medical students, nurses and doctors. We leave Saturday morning at 6 am to make a flight in Port-au-Prince which is a 5 hour bus ride away.
Q: What are some common conditions and diagnoses that you saw there?

Dr. M: Most of the patients have many of the same problems we see here in the U.S.: upper respiratory infections, acid reflux, musculoskeletal complaints and lots of hypertension. There does seem to be a group of symptoms that relates to the poverty of the region: headaches (from hypertension and carrying things on their head), back pains (from hard labor), burning eyes (from charcoal cooking, dust and sunlight), acid reflux (from not eating regularly), and vaginitis (lack of hygiene). Every year we have something a bit different like urosepsis, an abscess to drain, or TB with a large effusion. We also give out lots of glasses based on eye exams.

Q: What was donated by the pharmacy and how did it help with your service?

Dr. M: The Valley pharmacy has been a huge contributor to our efforts in Haiti. Every year, even the year I did not go, Valley has donated funds and made available excellent pricing in the form of wholesale prices for the meds we need. The number of people we can serve when we go is literally doubled by the giving of the Valley Hospital pharmacy.

Q: What did you and your staff do during down time during the trip?

Dr. M: During our down time we play with the kids and relax in the bucolic farm setting of the orphanage. I have played pick-up soccer with them each time I go. Because it is a church group, we often have some time to reflect on our experiences there.

Q: Where can someone who is interested in medical missions sign up or get more information?

Dr. M: We are planning our trip for 2017 now. We are also thinking of expanding to 2 trips a year. Each year the personnel for the trip has to be put together depending on the availability of slots and needs for different skill sets.